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# FOLLOW-UP ACTIONS TO THE RECOMMENDATIONS OF THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT: REPRODUCTIVE RIGHTS AND REPRODUCTIVE HEALTH

## Concise report on world population monitoring, 1996: reproductive rights and reproductive health

## Report of the Secretary-General

SUMMARY

The present report has been prepared in accordance with the new terms of reference of the Commission on Population and Development and its topic-oriented and prioritized multi-year work programme, which were endorsed by the Economic and Social Council in its resolution 1995/55.

It provides a summary of recent information on selected aspects of reproductive rights and reproductive health and covers such topics as entry into reproductive life; reproductive behaviour; contraception; abortion; maternal mortality and morbidity; sexually transmitted diseases, including human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS); reproductive rights; and population information, education and communication with respect to reproductive rights and reproductive health. The preliminary, unedited version of the full report is available as a working paper in document ESA/P/WP.131.

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## INTRODUCTION

1. Reproductive health has been defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity in all matters relating to the reproductive system and to its functions and processes (United Nations, 1995a). Thus, reproductive health goes beyond the child-bearing ages to encompass problems that may arise in both the earlier and the post-reproductive years. Further, reproductive health implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. The attainment of reproductive health also enables women to go safely through pregnancy and childbirth and provides couples with the best chance of having a healthy infant (United Nations, 1995a).

2. Reproductive rights are central to the achievement of reproductive health. Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights instruments and other consensus documents. The definition of reproductive rights recognizes the basic right of couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to make decisions concerning reproduction, free of discrimination, coercion and violence (United Nations, 1995a). Implicit in this is the right of men and women to be informed about and to have access to safe, effective, affordable and acceptable methods of family planning of their choice.

3. The broad and comprehensive approach to reproductive health reflected in the above definitions contrasts with various previous approaches dealing with reproduction. Those earlier approaches focused on specific aspects of reproductive health. Family planning programmes, for example, have concentrated on providing information and services on contraception. Maternal and child health programmes have similarly focused on promoting the health of mothers and their young children, while safe motherhood programmes have emphasized the need to ensure that pregnant women receive adequate prenatal care, safe delivery and postnatal care. They have also sought to address the high risks that women in many contexts face in relation to child-bearing.

4. Reproductive health incorporates all of those aspects in a comprehensive manner. While acknowledging the importance of family planning, the approach recognizes that reproductive health is not limited to child-bearing ages alone and that reproductive health concerns men as well as women. It also recognizes that to address reproductive health issues successfully, there is a need to address the reproductive rights of men and women and the socia` behaviour and cultural practices that affect reproductive health outcomes.

5. The approach to reproductive health is based on the premise that the health status of individuals at any given time is affected by their experiences at earlier ages. The reproductive health of men and women in child-bearing ages, for example, reflects not only their current experiences but also their health status during infancy, childhood and adolescence. Similarly, health status beyond the reproductive ages may reflect reproductive experiences at earlier

life stages. The experiences of one generation also have implications for the health of the next generation.

6. The present report provides a global review of selected aspects of reproductive rights and reproductive health. The topics covered include entry into reproductive life; reproductive behaviour; contraception; abortion; maternal mortality and morbidity; sexually transmitted diseases, including human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS); policy issues related to reproductive rights; and population information, education and communication with respect to reproductive rights and reproductive health.

7. To the extent possible, the reproductive rights and reproductive health of both men and women have been reviewed in the present report. However, data collection and research have until recently focused primarily on the reproductive and contraceptive behaviour of women. It is only during the past few years that demographic and health surveys have begun to include samples of men. The need to collect data and to conduct research on the reproductive attitudes and behaviour of both men and women has become more imperative given the renewed emphasis on the shared responsibility of partners in matters related to reproduction. Information is also lacking on the reproductive health of adolescents and of older men and women, who are usually not the subject of inquiry in demographic and health surveys.

## I. ENTRY INTO REPRODUCTIVE LIFE

8. Initiation of reproductive capability generally occurs in the second decade of life. The events which define entry into reproductive life, and their timing, are important determinants of both fertility and reproductive health and have important implications for the future life course of individuals. The stage of life during which individuals reach sexual maturity has come to be known as adolescence. Adolescence is the period of transition from childhood to adulthood. Although the change is biological, the duration and nature of adolescence is primarily a social construct and thus varies greatly from culture to culture. This review refers to the age range of 10-24 years but focuses mostly on age group 15-24, which the World Health Organization (WHO) refers to as young people. Within this age span lies much of the variation seen between countries and population subgroups in the events that define the beginning of reproductive life.

9. Adolescence is a period of development that is increasingly recognized both as an important determinant of future health and as a specially vulnerable period of life. In particular, increasing concern has been expressed about sexual risk-taking among young people, and the consequences of such behaviour, such as teenage pregnancy and the occurrence of sexually transmitted diseases, including HIV. The challenges of addressing the needs of adolescents are compounded by demographic factors. It has been estimated that in 1995 young people (ages 15-24 years) make up over 14 per cent of the total population in more developed regions and almost 20 per cent in the less developed regions (United Nations, 1995b).

10. In a number of societies, menarche signifies maturity and the readiness to marry or commence sexual activity. Studies documenting the age at menarche show that the age of onset varies by approximately five years between different population groups. The average age for each region indicates a younger age at onset in the more developed than in the less developed regions. Age at menarche has fallen in most developed countries. In developing countries, the decline is less well documented, but there is some evidence of a fall in age at onset in a number of population groups. The fall in age at menarche implies an earlier potential to reproduce. However, in general, it would appear that the effect of this biological factor has been offset by other influences, especially by increases in age at first marriage.

11. Traditionally, age at marriage has been regarded as marking the initiation of sexual activity and, therefore, the beginning of exposure to reproduction. Marriage may take widely different forms, ranging from formal unions approved under civil or religious law, to cohabiting or even visiting relationships. Despite the difficulties surrounding definitions of marriage, it is possible to identify some broad patterns in the timing of the beginning of sexual exposure of young women and men by examining the age at marriage.

12. Changes in the timing of first marriage around the world are well documented and it is clear that age at first marriage among women has risen dramatically in many countries. In the developing countries with data from the Demographic and Health Surveys (DHS), changes in the age at marriage can be examined by comparing the experience of women in different cohorts. The surveys use a broad definition of marriage which includes both formalized and informal unions. The data indicate that the proportion married by age 20 among young women (those aged 20-24 at the time of the survey) is considerably lower than that among older women (aged 40-44 at the time of the survey) in nearly all countries. The shift towards later marriage is most pronounced in the Asian countries: taking the average for eight countries shows that 57 per cent of women currently aged 40-44 years first married before age 20; the corresponding figure for women currently aged 20-24 years is 37 per cent. In Africa, the reduction in the average proportion married by age 20 has been almost as sharp - from 72 per cent to 55 per cent - but the prevalence of teenage marriage remains much higher than in Asia. In Latin America and the Caribbean, changes in the timing of first marriage have been more modest and the average proportion married before age 20, 42 per cent, is somewhat higher than in Asia.

13. Age at marriage for women has also risen in the past 20 years in the developed countries, although information on trends in age at marriage is not comparable to that for developing countries because most data derived from civil registration deal with legal marriage only. In 1970, the typical average age at first marriage in Northern and Western Europe was 22-23 years. By 1990, age at marriage in many countries in Northern and Western Europe had risen to 25-27 years. Increases are also observed in Northern America. In Eastern and Southern Europe changes in marriage ages have been more modest.

14. In most countries there is a general trend towards later marriage with increased educational level. Urban-rural residence represents a further influence on marriage ages for women. DHS data show that women with at least 10 years of education marry between two and seven years later than those with

less than primary education. Women living in urban areas typically marry later than their rural counterparts although the urban-rural gap varies considerably. In many developing countries, there is a 20 per cent or larger difference in the proportion marrying by age 20. In others, the difference is small.

15. Differences in the age at marriage between men and women have narrowed over time in many countries in Africa, most notably in Northern Africa, Asia and many countries in Latin America and the Caribbean. The convergence has been most marked in countries where differences were the largest. In Northern America and Europe, the gaps between the sexes have contracted further in recent decades.

16. In Europe, the upward trend in age at marriage has coincided with an increase in the proportion cohabiting. Recent data show that at ages 15-19, the proportions cohabiting range between nearly zero and 20 per cent. The prevalence of cohabitation peaks at ages 20-24, with a range of approximately 10-40 per cent, and declines thereafter. The major reason for the decline in informal cohabitation after age 25 is the growing dominance of legal marriage. Cohabitation may thus be a prelude or an alternative to marriage.

17. Delays in the timing of first marriage have played a key role in the fertility decline in many countries because most births continue to occur within marriage. Increases in the age at marriage, however, do not necessarily translate into the shortening of the reproductive life span. Premarital births are increasing in a number of countries around the world. Furthermore, the prevalence of sexually transmitted diseases among unmarried adolescents suggests that premarital sexual activity is not uncommon and may be increasing.

18. A growing body of survey data reveals wide variability in sexual behaviour among young people. In some areas of the world sexual activity begins early and is frequently premarital, while in others it is dictated by strong social sanctions and commonly coincides with marriage, although this, too, may occur at a very early age. Despite the paucity of systematic data and the variability in sexual behaviour of young people, some broad patterns emerge from the evidence.

19. In most areas of the world, men report an earlier age at sexual initiation than women, a greater number of partners and a longer period between sexual initiation and marriage. They are more likely than women to report premarital sexual activity. Age differences between partners have important implications for transmission of sexually transmitted diseases. Men typically have younger female partners, which increases the vulnerability of younger women to sexually transmitted diseases and HIV infection. Relationships between older men and younger women are reported to be increasingly common in some parts of Africa.

20. In the industrialized countries, there are indications of an increase in the overall proportion of young people who are sexually active. Age at marriage has increased; there is evidence of a fall in the age at sexual initiation; and a greater proportion of adolescents are involved in cohabiting relationships.

21. In sub-Saharan Africa and Latin America and the Caribbean, age at marriage has increased. Age at sexual initiation appears to have remained unchanged, although sexual activity begins at an early age in many countries. Increases in

age at marriage, in the absence of changes in age at sexual initiation, have meant that more young people have been exposed to premarital sexual activity.

22. Little is known about the sexual behaviour of young people in Asia. It is typically assumed that premarital sexual activity is uncommon and is subject to strong societal constraints. Evidence is sparse but a few studies indicate that sexual initiation coincides with marriage for the majority of young women, or is a prelude to marriage. Thus, any rise in age at marriage will also increase the age at sexual initiation.

## II. REPRODUCTIVE BEHAVIOUR

23. The current total fertility rate (TFR) for the world as a whole is estimated to be 3.1 children per woman (United Nations, 1995b). This average, however, conceals a large diversity between and within regions. The gap between the more developed regions (TFR of 1.7) and the less developed regions (TFR of 3.5), although narrower than in the past, remains sizeable. The highest TFR is observed in Africa (5.8), followed by Latin America and the Caribbean (3.1) and Asia (3.0). At the country level, current fertility rates range from 7.6 in Yemen to 1.2 in Italy and Spain.

24. During the past decade, fertility has continued its downward trend. At the world level, the average number of children per woman declined from 3.6 in 1980-1985 to 3.1 in 1990-1995. The underlying change in reproductive behaviour, however, differs greatly by region. In the more developed regions, fertility, which has been below replacement since the late 1970s, experienced only a slight decline, whereas in the less developed regions fertility fell from 4.2 to 3.5. The observed reduction was more modest in the least developed countries, where fertility declined from 6.4 to 5.8 children.

25. In recent decades, adolescent child-bearing has emerged as an issue of increasing concern throughout the developing and the developed world. There is a growing awareness that early child-bearing poses a health risk for the mother and the child and may truncate a girl's educational career, threatening her economic prospects, earning capacity and overall well-being.

26. It is estimated that world wide about 15 million girls aged 15-19 give birth each year and that about 11 per cent of all babies are currently born to adolescents (United Nations, 1995b). There is, however, considerable variation across regions. The level of adolescent fertility in the least developed countries (140 births per 1,000 women under age 20) is twice as high as that in developing countries (65 births per 1,000) and four times higher than that in the developed countries (32 births per 1,000). Within the developing regions, adolescent fertility rates are highest in Africa (136 births per 1,000), followed by Latin America and the Caribbean (79 births per 1,000) and lowest in Asia (45 births per 1,000). High rates of adolescent child-bearing are generally linked to a pattern of early marriage.

27. Although adolescent fertility is increasingly perceived as an issue of social and policy concern, fertility rates among women under age 20 have been falling alongside overall fertility rates world wide, owing to rising age at

marriage, increasing educational opportunities for young women and increased use of contraception. There are, however, some exceptions to the overall downward trend, for example in Haiti, India and the United States of America.

28. Education has long been recognized as a crucial factor influencing reproductive behaviour. According to a recent United Nations study, female education is universally associated with lower fertility (United Nations, 1995c). Countries in Latin America display the largest fertility gaps between better educated and uneducated women, ranging from 3 to 5 children per woman. Fertility differentials by education are not uniform across countries, suggesting that the resultant effect of women's education is conditioned by socio-economic development, social structure and cultural context. In contemporary developing societies, the impact of individual schooling on child-bearing tends to become stronger as the socio-economic conditions and the overall educational level of the society improve.

29. The timing of the onset of child-bearing has important implications for individuals, families and societies. In most countries, women's average age at first birth occurs within one and two years after first marriage. However, marriage is not the only context within which child-bearing takes place. In many developed countries, the rapid increase in child-bearing outside marriage, closely linked to the rise in cohabitation, constitutes one of the most significant recent transformations in family-building patterns. In the developing regions, out-of-wedlock child-bearing is relatively rare in Asia, but commonplace in Africa and Latin America and the Caribbean, reflecting the high prevalence of consensual unions.

30. The timing of entry into motherhood is remarkably similar across a wide range of developing societies: it tends to occur between ages 19 and 22. In most developed countries, entry into motherhood occurs at a later age, usually between ages 22 and 27. The trend observed during the past decade in both developing and developed societies has been towards a delayed pattern of family formation. The duration of women's child-bearing span, that is, the average number of years between women's first and last birth, is longest in Africa (ranging from 15 to 20 years), followed by Asia (11 to 17 years) and Latin America and the Caribbean (11 to 16 years).

31. Fertility preferences vary considerably across regions. Desired family size is largest in sub-Saharan Africa (where it ranges from four to eight children), followed by Asia (three to five children), Northern Africa (three to four children) and Latin America and the Caribbean (three to four children). The observed trend points towards women's increasing preference for smaller families.

32. The prevailing gap between women's ideal family size and actual child-bearing suggests that women's reproductive aspirations are seldom fulfilled. The inadequate control women have over their reproduction is also evident from the high prevalence of unplanned child-bearing. The percentage of births reportedly unwanted ranges from 2 to 26 in Africa, 6 to 21 in Asia and 5 to 35 in Latin America and the Caribbean, and the percentage of births reportedly mistimed ranges from 6 to 52 in Africa, 8 to 28 in Asia and 13 to 25 in Latin America and the Caribbean.

33. In the developed countries, a family with two children is the dominant ideal and, in many cases, the preferred number of children is above the actual total fertility rate. However, the number of unintended births is relatively large, despite the high prevalence of contraceptive use. In the United States, for example, 12 per cent of all births were reported as unwanted and 27 per cent as mistimed.

34. Between 8 and 12 per cent of all couples experience some form of infertility during their reproductive lives, a problem affecting 50-80 million people world wide (WHO, 1991). In a small proportion of couples (under 5 per cent) the underlying causes of infertility are attributable to anatomical, genetic, endocrinological or immunological factors. However, in the majority of cases, problems of infertility arise from preventable causes, such as untreated infection from sexually transmitted diseases, post-partum and post-abortion complications or female genital mutilation.

35. Past studies have documented unusually high incidence of impaired fertility in Africa, particularly in Central Africa. However, recent DHS data do not detect high levels of primary infertility: the proportion of childless women among ever-married women aged 40-44 does not exceed 6 per cent in any of the surveyed countries. The prevalence of disease-induced sterility in Africa, however, is significantly higher when secondary infertility is examined: the proportion of women aged 30-34 subsequently infertile is estimated to be above 20 per cent in Benin, Botswana, Côte d'Ivoire, Ghana, Liberia, Mali, Mauritania, Nigeria, Senegal, the Sudan, Uganda and Zimbabwe and above 30 per cent in Cameroon (Larsen, 1994).

36. A number of factors associated with the pattern of child-bearing may adversely affect the survival and well-being of mothers and children. Pregnancies too early or too late in the maternal life course, high-parity pregnancies and closely spaced pregnancies are considered to pose higher-than-normal risks to children's and women's health. DHS data reveal that the percentage of births subject to these risks is remarkably high, ranging from 53 to 73 in Africa, 38 to 79 in Asia and 46 to 66 in Latin America and the Caribbean. High parity is the most common risk factor, followed by short birth interval.

37. Although changes in the age, parity and birth-spacing distributions of fertility have the potential of reducing maternal mortality, the majority of women who die from pregnancy, abortion or childbirth do not fall within these high-risk categories. Socio-economic conditions, education, nutrition and health care are often more important determinants of women's health and survival. Coverage of maternity services varies greatly between countries. In 15 out of 44 developing countries, the proportion of births for which women received antenatal care was below two thirds, and in 17 out of 45 countries, less than half of the deliveries were assisted by a trained professional.

## III. CONTRACEPTION

38. Family planning is an integral part of reproductive health. Since the 1960s there has been a sustained increase in the use of contraception in developing countries. In the early 1960s, when TFR in the less developed regions averaged 6.1 children per woman, the level of contraceptive prevalence - current use among couples with the woman of reproductive age - was probably under 10 per cent in the developing countries, while recent surveys show that contraceptive prevalence in those regions had risen to 53 per cent by 1991. In developed countries, contraceptive prevalence averaged 71 per cent, and for the world as a whole the average was 57 per cent (see table 1). The level of contraceptive use in Africa, at 19 per cent, is far below the average level for the other developing regions: 79 per cent in Eastern Asia; 43 per cent in the remainder of Asia and Oceania; and 59 per cent in Latin America and the Caribbean.

Table 1 Average prevalence of specific contraceptive methods, by region a/

(Percentage of couples with the woman in the reproductive age)

| Major area and region | All methods (1) | Modern methods b/ (2) | Sterilization Female (3) | Sterilization Male (4) | Pill (5) | Injectable (6) | IUD (7) | Condom (8) | Vaginal barrier methods (9) | Rhythm (10) | Withdrawal (11) | Other methods (12) |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| World | 57 | 49 | 18 | 4 | 8 | 1 | 12 | 5 | 1 | 3 | 4 | 1 |
| Less developed regions | 53 | 48 | 21 | 4 | 6 | 2 | 13 | 2 | 0.2 | 2 | 2 | 1 |
| Africa | 19 | 15 | 1 | 0.1 | 7 | 2 | 4 | 1 | 0.2 | 2 | 1 | 1 |
| Asia and Oceania c/ | 58 | 54 | 24 | 5 | 5 | 2 | 16 | 2 | 0.2 | 2 | 2 | 0.1 |
| Eastern Asia c/ | 79 | 79 | 33 | 9 | 3 | 0.1 | 31 | 2 | 0.3 | 0.4 | 0.1 | . |
| Other countries | 43 | 36 | 17 | 2 | 6 | 3 | 5 | 3 | 0.1 | 3 | 3 | 1 |
| Latin America and the Caribbean | 59 | 49 | 21 | 1 | 17 | 1 | 6 | 2 | 1 | 6 | 3 | 0.5 |
| More developed regions d/ | 71 | 51 | 8 | 5 | 17 | 0.1 | 5 | 14 | 2 | 6 | 12 | 1 |

Source: World Population Monitoring, 1996 (United Nations publication, forthcoming).

Note: These estimates reflect assumptions about contraceptive use in countries with no available data.

a/ Based on the most recently available survey data; average date 1991.

b/ Including methods in columns 3-9.

c/ Excluding Japan.

d/ Australia-New Zealand, Europe, Northern America and Japan.

39. The transformation in contraceptive practice reflects the growing desire of couples and individuals to have smaller families and to choose when to have their children. It also reflects the great increases in the availability of effective modern contraceptives in developing countries and of associated family planning information and services. Although the recent changes in the developed regions concern primarily the choice of specific birth control methods rather than the overall level of contraceptive use, the introduction of modern methods has also brought about a transformation in contraceptive practice.

40. Most users of contraception are women and most of them use modern methods. Relatively effective clinic and supply ("modern") methods account for an estimated 87 per cent of contraceptive use worldwide. The three main "female" methods - female sterilization, intra-uterine devices (IUDs) and oral pills - account for over two thirds of contraceptive practice world wide and three fourths of use in the less developed regions. Modern methods in general make up a larger fraction of contraceptive use in the developing than in the developed countries, estimated at 91 per cent and 73 per cent, respectively. Prevalence of clinic and supply methods averages 51 per cent in the more developed regions and 48 per cent in the less developed regions. The prevalence of non-supply and traditional methods differs more between the developed and the developing countries, 20 per cent and 5 per cent, respectively. This group of methods includes periodic abstinence or rhythm, withdrawal (coitus interruptus), abstinence, douching and various folk methods. The higher levels of use of these methods in the developed countries reflects the continuing influence of patterns of fertility control established before the era of modern contraceptive methods and also the lack of wide availability of newer methods in some countries. Some developed countries where the use of traditional methods was widespread around 1970 have undergone a marked transition to the use of modern methods: Belgium, France and Hungary are examples. However, some countries in Eastern Europe with surveys conducted in the 1990s still show high prevalence levels of traditional methods: examples include the Czech Republic, Romania and Slovakia.

41. Most developing countries with available trend data show a substantial recent increase in contraceptive use. Consideration of trends between the most recent available survey and surveys conducted about 10 years earlier, shows that increases in contraceptive use have been the most rapid in countries that had a moderate level of use at the start of the period. Where prevalence was in the range of 15-50 per cent, the level of contraceptive use subsequently grew by more than 1.0 per cent per annum in over 80 per cent of the countries. By contrast, annual increases of 1.0 points or more occurred in about 55 per cent of the developing countries where prevalence was initially either below 15 per cent or above 50 per cent. Although the average level of contraceptive use remains much lower in Africa than in other developing regions, surveys conducted in the past few years have continued to add to the evidence of increasing use of contraception in continental sub-Saharan Africa.

42. With respect to the use of particular types of contraception, rising use of female sterilization is the most important trend in both developed and developing countries. None the less, there are many individual countries where other methods are responsible for most of the recent trend. While there is a general tendency for modern methods as a group to become more predominant over time, there is little sign that the widely varying national patterns of use are converging to the same method mix. Only rarely does a single type of contraception account for most of current use.

43. Recent surveys indicate a significant rise in the level of use of condoms in several countries, suggesting that campaigns promoting this method are having an effect. On average, condoms account for only about 8 per cent of contraceptive practice reported by married women. However, men tend to report more use of this method than do women. Levels of condom use among unmarried men

are usually higher than among married men, even though the general level of contraceptive use is higher among the married men.

44. Despite the recent rapid growth in the use of contraception, a variety of indicators suggest that the level of unmet need remains high, with about 20-25 per cent of couples in developing countries (except China) at risk of an unwanted or mistimed pregnancy, but not using contraception. In Africa and in some countries in other regions, substantial proportions of the population still have no knowledge of any type of contraception. Furthermore, the percentage of women who know of a place to obtain family planning information or services is sometimes much lower than the percentage of those who have heard of a method. In Asia and Northern Africa, 90 per cent or more of women knew of a service outlet in over three fourths of the countries with available data, and in Latin America and the Caribbean this level was reached in about 60 per cent of countries. However, this level of knowledge of services was observed in only 2 of 23 countries in sub-Saharan Africa (Botswana and Zimbabwe).

45. In general, problems of limited knowledge of and access to family planning reflect the difficulty many Governments have experienced in extending services nationwide rather than a deliberate policy to restrict access. By 1995, only two Governments (out of 190) had an official policy of limiting access to modern contraceptive methods, while 82 per cent of the Governments provided direct support for family planning services. Ratings of various aspects of family planning policy and programme performance carried out in 1982, 1989 and 1994 indicate that there was rapid growth in programme effort and method availability during the 1980s. A further increase was noted in many countries since 1989, but at a slower pace than between 1982 and 1989. Based on knowledgeable observers' ratings of the availability of five types of contraception, in 1994 condoms were estimated to be readily available to about two thirds of the population of developing countries, and oral pills, IUDs and female sterilization to about 60-65 per cent. Male sterilization was judged to be readily available to slightly less than 50 per cent of the population. Despite substantial recent improvements, contraceptive methods are much less readily available in sub-Saharan Africa than in other regions.

46. In most developing countries levels of contraceptive use are substantially higher among urban and well-educated women than among their rural and less educated counterparts. During the past 10-15 years, the average size of the social differentials in contraceptive practice has changed very little, although this is partially due to offsetting changes in different countries. Where contraceptive use had been low to start with, differentials usually widened, and the reverse was true in countries where use levels were already high at the earlier date in urban areas or among highly educated women.

47. Many surveys have limited questions about current contraceptive use to married women. Recently, more surveys have posed these questions to unmarried women, and these data show that an exclusive focus on married women leaves out a significant proportion of contraceptive users in many cases. In sub-Saharan Africa and in the more developed regions with such information available, women not in a union make up about one fourth of all contraceptive users, on average, and in Latin America and the Caribbean nearly 10 per cent.

48. While some couples use a single contraceptive method successfully for many years, most are likely to stop contraceptive use or switch from their first method at some point. Studies of contraceptive discontinuation show that within a year of starting to use the pill, typically 40-60 per cent of women will have stopped, 15-30 per cent for IUD, more than 50 per cent for the condom and about 40-60 per cent for periodic abstinence (including the calendar rhythm method). Reasons for stopping vary by method. In general, methods that are highly effective at preventing pregnancy have a high incidence of side-effects and vice versa.

49. Side-effects and worries about them stand out consistently in studies of different populations as one of women's major concerns about modern contraceptive methods. Health concerns and side-effects are frequently cited as the reason for discontinuing the methods, and in many cases a substantial proportion of women who are at risk of an unwanted pregnancy report that health concerns are their main reason for not using contraception. At the same time, the recent rise in the level of contraceptive use is due almost entirely to increased use of modern methods. The evidence suggests that, although modern methods have worked well for many couples, their use still presents difficult choices for many others. The rapidly increasing reliance on the permanent method of surgical sterilization must be in part a reflection of the drawbacks of the temporary methods and services that are currently available.

50. Although most information about contraceptive use and unmet need is derived from surveys of women, recently more surveys have asked men about these topics. This information is only now beginning to be analysed in detail. In some countries a substantial proportion of the women with an apparent unmet need for contraception report that they are not using any method because of opposition from their spouse, which could refer either to opposition to contraception in general or to a disagreement about the number and timing of children. The available evidence about disagreements between spouses points to a variety of situations whose relative importance is often impossible to quantify. Some men clearly do expect to make the choice about using contraception (even if it is the woman who uses the method), while others view this as being completely the woman's responsibility. In some countries, many people do not know their partner's views about family planning. The question of how inter-spouse disagreements are resolved in practice deserves more attention than it has received to date, and this requires obtaining comparable information from both men and women.

## IV. ABORTION

51. Approximately 25 million legal abortions were performed world wide around 1990, or one legal abortion for every six births. This estimate must be considered the minimum number of legal abortions, as no attempt has been made to estimate the magnitude of unreported legal abortions. Given the clandestine nature of unsafe abortion, its incidence is very difficult to gauge. WHO has estimated that some 20 million unsafe abortions are performed each year, or one unsafe abortion for every seven births (WHO, 1994). Thus, at a minimum, some

45 million abortions a year are thought to be taking place globally, that is, nearly one abortion for every three live births.

52. Induced abortion has attained high public visibility in many countries, both developed and developing. In some cases, public concern has been voiced primarily because of the alarmingly high levels of maternal mortality and morbidity that have resulted from unsafe abortion. In others, the visibility has resulted more from public debate concerning the moral and legal status of abortion and the role that the State should play in permitting or denying access to induced abortion.

53. At the International Conference on Population and Development in 1994, the issue of abortion proved to be one of the most contentious, with much of the debate dealing directly or indirectly with various abortion-related issues. At the end of the debate, delegations agreed on the following wording: "In no case should abortion be promoted as a method of family planning. All Governments and relevant intergovernmental and non-governmental organizations are urged to strengthen their commitment to women's health, to deal with the health impact of unsafe abortion 1/ as a major public health concern and to reduce the recourse to abortion through expanded and improved family planning services ..." (United Nations, 1995a, Chap. I, resolution 1, annex, para. 8.25).

54. Induced abortion is one of the oldest methods of fertility control and one of the most widely used (United Nations, 1992, 1993 and 1995d). It is practised both in remote rural societies and in large modern urban centres and in all regions of the world, although with differing consequences. In countries where abortion is legal and widely available, abortions generally pose a relatively small threat to women's reproductive health. Where abortion is illegal, however, it is usually performed in medically substandard and unsanitary conditions, leading to a high incidence of complications and resulting in chronic morbidity and often death. Indeed, WHO has estimated that more than 70,000 women die annually as a result of complications arising from unsafe abortion. Moreover, long-term consequences of unsafe abortion may include chronic pelvic pain, pelvic inflammatory disease, tubal occlusion, secondary infertility and increased risk of spontaneous abortion in subsequent pregnancies (WHO, 1994).

55. Substantial variations exist in incidence of unsafe abortion by region. The incidence of unsafe abortion varies from a high of 30 or more unsafe abortions per 1,000 women aged 15-49 years in Eastern and Western Africa, Latin America and the Caribbean and the former USSR to fewer than 2 unsafe abortions per 1,000 women aged 15-49 years in Northern Europe and Northern America (WHO, 1994). Some of the variations in the incidence of unsafe abortion can be explained by the less restrictive nature of abortion laws in Northern Europe and Northern America (11 of 12 countries permit abortion on request or for economic or social reasons), as compared with Eastern and Western Africa and Latin America and the Caribbean (2 of 45 countries permit abortion on request or for economic or social reasons). Lack of legal restrictions on abortion, however, does not necessarily guarantee access to safe abortion, as evidenced by the relatively high incidence of unsafe abortion in the former USSR (estimated by WHO at 30 unsafe abortions per 1,000 women aged 15-49 years), despite the availability of abortion on request since 1956.

56. In line with the heightened interest in adolescent reproductive behaviour, adolescent abortion is a growing area of concern. Because adolescents are sometimes unwilling or unable to seek appropriate health care or wait longer in the gestation period to obtain help, induced abortion generally presents a greater risk to the health and life of the adolescent than to an adult woman. According to recent United Nations estimates, abortion among adolescents has accounted for 15-25 per cent of total reported legal abortions in a number of developed and developing countries.

57. Based on information available for 193 countries, the overwhelming majority of countries (98 per cent) permit abortions to be performed to save the pregnant woman's life (United Nations, 1992, 1993 and 1995d). In a number of those countries, criminal laws specifically allow abortion on this ground. In others, however, one must look to other laws or court decisions to determine if there are exceptions to a general prohibition of abortions. For example, in Honduras, the Code of Medical Ethics permits abortion to save the woman's life; in Nepal, the rules of the Medical Council have been interpreted to permit abortion in various situations; and in Ireland the Supreme Court has ruled that an abortion can be performed to preserve the life of the pregnant woman. In yet other countries, the criminal law principle of necessity can be invoked to exempt from punishment the performance of an abortion to save a pregnant woman's life. Examples include the Central African Republic, the Dominican Republic, Egypt and the Philippines.

58. Abortion to preserve the woman's physical health is permitted in 119 countries (62 per cent). Fewer countries (95, or 50 per cent) allow abortion to preserve the woman's mental health, and 81 countries (42 per cent) permit it when pregnancy has resulted from rape or incest. The number declines to 78 countries (40 per cent) when there is the possibility of foetal impairment and to 55 countries (29 per cent) when there are economic or social reasons. Finally, in 41 countries (21 per cent), abortion is available on request.

59. An examination of abortion policies in terms of population discloses that 96 per cent of the world population lives in countries that permit abortion to save the woman's life, 75 per cent lives in countries permitting abortion to preserve the woman's physical health, 69 per cent in countries where abortion is legal to preserve the woman's mental health and 72 per cent in countries where abortion is allowed when the pregnancy results from rape or incest. The percentage declines to 64 when there is the possibility of foetal impairment and to 44 in countries that permit abortion for economic or social reasons. Finally, abortion is available on request to 38 per cent of the world population.

## V. MATERNAL MORTALITY AND MORBIDITY

60. Among the health and mortality indicators, levels of mortality show striking disparities according to levels of development. Maternal mortality is a sensitive indicator of the status of women in society, their access to health care and the adequacy of the health care system in responding to their needs. Information about levels and trends of maternal mortality is needed, therefore, not only to assess the risks of pregnancy and childbirth, but also for what it

implies about women's health in general and, by extension, their social and economic well-being.

61. It is extremely difficult to assess levels of maternal mortality at the national level. Doing so requires knowledge about deaths of women of reproductive age (15-49 years), the cause of death and also whether or not the woman was pregnant at the time of death or had recently been so. Yet, few countries register all births and deaths; even fewer register the cause of death; and fewer still systematically note pregnancy status on the death form.

62. Inevitably, countries with the least developed systems of vital registration are those with the worst health indicators. In such circumstances, alternative ways have to be developed for estimating levels of maternal mortality. A variety of innovative methodologies have been devised to overcome the absence of data in countries with poor or non-existent vital registration. For example, maternal mortality can be measured by incorporating questions on pregnancy and deaths into large-scale household inquiries, but this approach requires a large sample size and is expensive and time-consuming. A more cost-effective approach is the "sisterhood method", which adds on to existing household surveys a few simple questions about whether or not the sisters of the respondent are still alive. Much smaller sample sizes are needed because each respondent can provide information on a number of sisters. However, the results do not provide current estimates but give an idea of the levels of maternal mortality roughly 10 years earlier.

63. The best way to measure maternal mortality in the absence of vital registration is to identify and investigate the causes of all deaths of women of reproductive age - the Reproductive Age Mortality Survey (RAMOS). Multiple sources of information - civil registers, health facility records, community leaders, religious authorities, undertakers, cemetery officials, schoolchildren - must be used to identify all deaths. Subsequently, interviews with household members, health-care providers and facility records are used to classify deaths as maternal or otherwise (verbal autopsy). Although RAMOS studies are considered to be the "gold standard" for estimating maternal mortality, they are also time-consuming and complex to undertake, particularly on a large scale.

64. Because of the difficulties and costs involved, only nine developing countries have carried out RAMOS or household studies to estimate maternal mortality at the national level. In such circumstances, other methods have to be devised to provide broad estimates of the extent of the problem. WHO and UNICEF have developed new estimates of maternal mortality using a simple modelling strategy. This is based on existing data sets and uses two independent variables - general fertility rates and proportion of births that are assisted by a trained person - to predict values for countries with no sound national estimate of maternal mortality.

65. The model is primarily intended to be of use in countries with no estimates of maternal mortality or where there is concern about the adequacy of officially reported estimates. It provides figures on orders of magnitude rather than precise estimates of maternal mortality. The standard errors associated with the predicted maternal mortality ratios are very large. Moreover, the ratios

generated from the modelling exercise cover a 10-year time span (roughly 1982-1992). They cannot, therefore, be used for regular monitoring of trends. The figures pertain to around 1990 and should be seen as a recalculation of the earlier 1991 revision prepared by WHO rather than as indicative of trends since then.

66. Preliminary results of the new model are shown in table 2. The results indicate that maternal mortality is higher than previously estimated, with some 590,000 maternal deaths compared with 509,000, according to the earlier model. The most significant differences between the old and the new model are for Africa, where the maternal mortality ratio according to the new estimates is 878 per 100,000 live births, compared with the earlier estimate of 630 per 100,000. By contrast, the estimates produced by the new model for Asia and Latin America and the Caribbean show relatively small changes compared with the earlier model.

Table 2. Estimates of maternal deaths and maternal mortality ratios, 1990

| Major area and region | Maternal deaths | |
|---|---|---|
| | Number (thousands) | Ratio (per 100,000 live births) |
| World | 590 | 429 |
| More developed regions | 4 | 27 |
| Less developed regions | 586 | 479 |
| Africa | 238 | 878 |
| Asia | 323 | 383 |
| Europe | 3.2 | 36 |
| Latin America and the Caribbean | 23 | 194 |
| Northern America | 0.5 | 11 |
| Oceania | 2.0 | 382 |

Source: World Health Organization, Maternal Mortality Ratios and Rates: A Tabulation of Available Information, 4th ed. (Geneva, forthcoming).

67. If counting the total numbers of maternal deaths is difficult, estimating the causes of those deaths is even more so. Few studies collect information on the cause of death in a standard format or follow the categories of causes of death described in the International Classification of Diseases. However, based on the evidence of the few good community-based studies, it is possible to estimate the breakdown of maternal mortality by five major causes of death. A summary of the incidence of and mortality from the five major obstetric complications is given in table 3. There are significant regional variations

within these global totals. Abortion is likely to account for a larger percentage of overall maternal mortality in Latin America although the maternal mortality ratio is generally lower in that region than in most parts of Africa.

Table 3. Estimated global incidence and mortality from main obstetric complications world wide, 1990

| Obstetric complications | Number of cases a/ (thousands) | Number of deaths (thousands) | Percentage of all maternal deaths |
|---|---|---|---|
| Haemorrhage | 14 300 | 150 | 25 |
| Sepsis | 12 000 | 90 | 15 |
| Hypertensive disorders of pregnancy and eclampsia | 7 100 | 75 | 13 |
| Obstructed labour | 7 300 | 40 | 7 |
| Unsafe abortion | 19 900 | 75 | 13 |
| Other direct causes | 3 600 | 50 | 8 |
| Indirect causes | 13 500 | 110 | 19 |
| Total | 77 600 | 590 | 100 |

Source: World Health Organization, Maternal Health and Safe Motherhood Programme (Geneva), unpublished estimates.

a/ Estimated number of events, not women.

68. In these calculations it has been assumed that each complication is a discrete event and, therefore, that complications arise in some 56 per cent of pregnancies ending in live birth. The severity of the complication will, of course, vary and WHO estimates that almost 15 per cent of all women develop complications serious enough to require rapid and skilled intervention if the woman is to survive without lifelong disabilities. Such disabilities include obstetric fistula (damage to the bladder and/or rectum); reproductive tract infections; pelvic inflammatory disease; infertility; anaemia; prolapse; and damage to the brain, kidneys and cardiovascular system.

69. The complications that cause the deaths and disabilities of mothers also damage the infants they are carrying (see table 4). Of the approximately 8 million infant deaths each year, almost two thirds occur during the neonatal period, before the baby is one month old. Every year there are 5 million neonatal deaths, of which 3.5 million occur within the first week of life and are largely a consequence of inadequate or inappropriate care during pregnancy, delivery or the first critical hours after birth. And for every newborn death another infant is stillborn.

Table 4. Effect of pregnancy complications on mother and baby

| Problem or complication | Most serious effects on mother's health | Most serious effects on newborn baby-foetus |
|---|---|---|
| Severe anaemia | Cardiac failure | Low birth weight, asphyxia, stillbirth |
| Haemorrhage | Shock, cardiac failure, infection | Asphyxia, stillbirth |
| Hypertensive disorders of pregnancy | Eclampsia, cerebrovascular accidents | Low birth weight, asphyxia, stillbirth |
| Puerperal sepsis | Septicaemia, shock | Neonatal sepsis |
| Obstructed labour | Fistulae, uterine rupture, prolapse, amnionitis, sepsis | Stillbirth, asphyxia, sepsis, birth trauma, handicap |
| Infection during pregnancy, sexually transmitted diseases | Premature onset of labour, ectopic pregnancy, pelvic inflammatory disease, infertility | Premature delivery, neonatal eye infection, blindness, pneumonia, stillbirth, congenital syphilis |
| Hepatitis | Postpartum haemorrhage, liver failure | Hepatitis |
| Malaria | Severe anaemia, cerebral thrombosis | Prematurity, intra-uterine growth retardation |
| Unwanted pregnancy | Unsafe abortion, infection, pelvic inflammatory disease, haemorrhage, infertility | Increased risk of morbidity, mortality; child abuse, neglect, abandonment |
| Unclean delivery | Infection, maternal tetanus | Neonatal tetanus, sepsis |

70. Aside from considerations of the numbers of deaths and disabilities, there is also the issue of the nature of a maternal death. The mothers who die are in the prime of life, at the summit of their social and economic productivity. They leave behind them families, many with young children, who must survive without the support of the prime caregiver, producer of food and generator of income.

71. The paucity of information about maternal ill-health has resulted in long neglect of the problem, neglect that the international community has only recently started to address. There is still much that has to be learned, not about the interventions needed to reduce maternal deaths, which have been known for many years, but about how to implement those interventions in a sustainable way in resource-limited settings. Although maternal mortality and morbidity are

major components of reproductive ill-health, addressing them requires interventions that differ, in several important ways, from the interventions needed to deal with other components of reproductive ill-health. In particular, it will not be possible to achieve sustainable reductions in maternal mortality in the absence of functioning district health systems, including widespread availability of maternal health care at the community level along with appropriate referral and management of complications and emergencies.

## VI. SEXUALLY TRANSMITTED DISEASES, INCLUDING HIV/AIDS

72. Until recently, the prevention and control of sexually transmitted diseases was a low priority for most countries and development agencies. Lack of awareness of the problem of sexually transmitted diseases and their complications and sequelae, competition for resources to control other important health problems and reluctance of public health policy makers to deal with diseases associated with sexual behaviour have all played a role in this neglect.

73. To date, most programmes for the prevention of sexually transmitted diseases have focused on prevention of complications (secondary prevention). The prevention of transmission of infection (primary prevention) is at present receiving increased attention because of the global HIV/AIDS epidemic and the identification of several sexually transmitted diseases as risk factors for the spread of HIV.

74. Currently in its second decade, the HIV epidemic continues to grow with thousands of new infections occurring every day. An estimated cumulative total of 18.5 million adults and 1.5 million children have been infected with HIV. Of all the infected cases, 7-8 million are women, about 70 per cent of whom are of child-bearing age. According to WHO, between 13 million and 15 million infected adolescents and adults, in addition to about half a million infected children, are alive today.

75. The longer-term dimensions of the HIV/AIDS pandemic cannot yet be forecast with confidence. However, on the basis of the available data on the current global status of the pandemic and recent trends in its spread, WHO has generated a plausible range of projected new HIV infections during the 1990s. In making projections of the future magnitude of the pandemic, WHO uses the lower limit of its estimated range of the HIV prevalence for each region. The results should thus be considered conservative.

76. During the current decade, WHO forecasts that about 10-15 million new cases of HIV infections may be expected in adults, mostly in developing countries. During the same period, WHO projects that as many as 5-10 million children will be HIV-infected through their mothers, the majority of them in sub-Saharan Africa. By the year 2000, 30-40 million HIV infections will have occurred, 90 per cent of which will be in developing countries. The projected cumulative total number of HIV-related deaths is predicted to rise to more than 8 million from its current total of 2 million. WHO also estimates that over 5 million children under age 10 years will be orphaned by the end of the 1990s as a result of the HIV-related deaths of their parents. The number of orphans will increase

further in the early years of the twenty-first century as a result of the death of those mothers who were infected with HIV in the 1990s.

77. The epidemic is having devastating effects on individuals, families and entire communities. For women, HIV infection has added its burden to risks related to sexually transmitted diseases, pregnancy and childbirth. The proportion of women with HIV and AIDS has increased, especially in developing countries. Young people are particularly affected by HIV and AIDS. It is estimated that 50 per cent of HIV infections occur in age group 15-24. This has an important impact on the economy of many countries since the age groups most affected - young and middle-aged adults - constitutes the bulk of the workforce. The socio-economic burden of sexually transmitted diseases, in terms of direct and indirect costs, is increasing rapidly.

78. Over the past 10 years, the response to HIV/AIDS has focused on prevention, as well as on care. Governments, non-governmental organizations, communities, associations and networks of people living with HIV/AIDS, international organizations and the health, education and other sectors, as well as the public and private sectors, have worked in partnership to develop a response to the epidemic.

79. The epidemiological trends of sexually transmitted diseases in various parts of the world are strikingly different. In the developing countries the epidemic is characterized by high incidence and prevalence; a high rate of complications; an alarming problem of anti-microbial resistance; and the interaction with HIV infection. It is estimated that about 333 million curable cases of sexually transmitted diseases occur globally every year, most of which are occurring in developing countries.

80. Sexually transmitted diseases have been a neglected area in public health in most of the developing countries despite the overwhelming facts of their impact on health, particularly for women and newborns. For several decades, sexually transmitted diseases have ranked among the top five conditions for which adults in many developing countries seek health-care services. In most industrialized countries, on the other hand, there has been a spectacular decline in the incidence of sexually transmitted diseases, particularly gonorrhoea and syphilis.

81. Chlamydia infection is by far the most common bacterial sexually transmitted disease in Europe. For some time its incidence had been seriously underestimated because of a lack of diagnostic facilities. In countries with an active chlamydia control policy, there has been a well-documented reduction in the number of cases, particularly in women.

82. Reliable data on the incidence of sexually transmitted diseases in developing countries are scarce, although prevalence surveys have been conducted in many countries, particularly in Africa. In general, the survey data show higher rates of gonorrhoea, syphilis and chlamydia than in comparable populations in Europe or Northern America. However, there is also a large variation in prevalence, with some populations having low levels of infection. It should be stressed that the prevalence rate of a bacterial sexually

transmitted disease is the result of both sexual exposure of the population and the proportion of infections adequately treated.

83. Women, especially young women, are more vulnerable than men to infection with a sexually transmitted disease and its complications (such as infertility, cancer and inflammatory diseases). The high prevalence of sexually transmitted diseases among women attending antenatal, family planning or gynaecological clinics in developing countries provides an indication of the extent of the problem of sexually transmitted diseases. For example, in studies in developing countries, up to 19 per cent of the pregnant women have been found to have gonorrhoea or chlamydia, up to 20 per cent to have syphilis.

84. Biologically women are more susceptible to most sexually transmitted diseases than men, at least in part because of the greater mucosal surface exposed to a greater quantity of pathogens during sexual intercourse. Women with a sexually transmitted disease are more likely than men to be asymptomatic, and, therefore, are less likely to seek treatment, resulting in chronic infections with more long-term complications and sequelae.

85. There are important overlaps between programmes for the prevention of HIV/AIDS and sexually transmitted diseases and care programmes and other components of reproductive health programmes. Family planning services and maternal health/antenatal care services offer an important opportunity for both diagnosis and treatment of sexually transmitted diseases, as well as information about their prevention, including safer sexual behaviour and related services such as the provision of condoms.

## VII. REPRODUCTIVE RIGHTS

86. Reproductive health and rights are relatively new subjects in the area of population policy. Reproductive health and rights are also a particularly controversial topic. They relate to areas of life that are the most intimate and personal such as sexuality, sexual relations and reproduction, as well as to matters that are central to how the members of a family relate to one another and how they perceive themselves. They are also linked with the status of women and the empowerment of women, matters which, themselves, provoke controversy in many countries.

87. Reproductive rights may be viewed as certain rights that all persons possess that will allow them access to the full range of reproductive health care. In particular, as formulated at the past three international conferences on population and at the Fourth World Conference on Women, these rights include the right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so. They also include the right to attain the highest standard of sexual and reproductive health and the right to make reproductive decisions free from discrimination, violence and coercion. Furthermore, the Programme of Action of the International Conference on Population and Development and the Platform for Action of the Fourth World Conference on Women make clear that all of these rights are grounded in national laws, international human rights instruments and other international consensus documents.

88. Although the concept of reproductive rights is of relatively recent origin, there is ample support for those rights in existing international documents and human rights treaties. For example, the final documents adopted at all three international conferences on population as well as at the Fourth World Conference on Women strongly assert reproductive rights. Drawing on the language originally formulated at the International Conference on Human Rights held at Tehran in 1968, each document provides that all couples and individuals have the right to decide freely and responsibly the number and spacing of their children and the information, education and means to do so. While the documents are not legally binding in terms of international law, they do bear great normative authority and have been endorsed by the vast majority of Governments.

89. Formal international treaties that are legally binding also support the concept of reproductive rights, if not by name. For example, the International Covenant on Civil and Political Rights (the Political Covenant), contains a number of provisions that are relevant to the right to make voluntary decisions about bearing children. Similarly, the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant) - the sister treaty to the Political Covenant - recognizes the right of persons to enjoy the highest standards of health and calls for special attention to be given to women before and after childbirth and to the reduction of infant mortality. With the approval of the Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention) in 1979, these reproductive rights are made explicit and strongly endorsed. National laws also support reproductive rights, with laws relating to maternal/child health care, access to the various forms of family planning, sex education and treatment and prevention of sexually transmitted diseases being common in both developing and developed countries.

90. One of the cornerstones of the concept of reproductive rights is the right of access to methods of family planning. This idea has been fundamental to definitions of reproductive rights from the beginning, appearing repeatedly in population and human rights documents as the right to have the "information and means" to decide freely and responsibly on the number and spacing of children. Without such access, reproductive rights have, practically speaking, no real meaning.

91. Adolescent reproductive behaviour has become an emerging world-wide concern. Most countries do not have coherent policies for the protection and maintenance of reproductive health in adolescents, partly because of the sensitivity of the subject. Several key issues concerning the reproductive rights of adolescents pertain to marriage. In many parts of the world, women's basic human rights are violated when they are given in marriage without their consent. Moreover, despite legislation designed to eliminate the practice, girls in many countries marry shortly after puberty and are expected to start having children almost immediately, in part because of a lack of alternative opportunities. The problems of early child-bearing are not only biomedical, but also result in reduced educational and economic opportunities for young mothers.

92. Many obstacles exist in the achievement of the goals of reproductive rights and reproductive health. Because of the sensitive and controversial character of the issues involved - in particular, sexuality, contraception, the empowerment of women and family relations - there is resistance to the expansion

of reproductive rights. Another major problem is conceptual in nature. In many countries, human and reproductive rights, as expressed in international documents, are not familiar to the general public and little information is disseminated on those rights. In addition, human and reproductive rights may seem abstract in their formulation or even foreign to local experiences, attitudes and traditions. The less educated are especially likely to lack knowledge about their rights. Also, women more than men are subject to restrictions on their personal status that prevent them from obtaining information on their rights. Thus, many women are not aware that they have reproductive rights; without such awareness they are unlikely to exercise those rights.

93. In the light of these obstacles, action to achieve reproductive rights and health is restricted in scope. One strategy to overcome such obstacles is to try to strengthen and make greater use of international treaty enforcement and monitoring mechanisms. Another strategy is to increase the provision of information and education on reproductive rights and reproductive health. Efforts can be increased to reach the millions of persons throughout the world who have little knowledge or understanding of reproductive health. These efforts can include furnishing basic facts on health and the reproductive system, as well as information on how reproductive health is closely connected to such matters as the age of marriage, education, the status of women and harmful practices such as female genital mutilation. Publicity can also be given to the existence at the international level of documents that countries have ratified which support rights in these matters, particularly the right to decide freely and responsibly on the number and spacing of children. Moreover, to be effective, provision of this information should be provided to medical personnel, religious leaders, government officials and non-governmental organizations.

94. Of critical importance is presenting the concept of reproductive rights in ways that are appropriate at the local level. One approach is to point to local laws that themselves support reproductive rights, such as the constitutions, population policies and health laws of various countries. Another is to draw on local social movements and traditions that support reproductive rights. A third approach is to relate "rights" language to the actual needs at the local level, needs for basic health services, family planning and education, for example. For the concepts of reproductive rights and reproductive health to be implemented at the local level, they need be integrated into existing social, political and religious structures and thus become part of the complex fabric of society.

## VIII. POPULATION INFORMATION, EDUCATION AND COMMUNICATION

95. In the field of population, the term information, education and communication is used as the strategic combination of all three processes in efforts to provide information on services, create public awareness and advocate for action on population and development issues. The term information, education and communication programme interventions is usually conceived as an integral part of a country development programme, which aims at achieving

measurable behaviour and attitude changes of specific audiences, based on a study of their needs and perceptions.

96. The implementation of the Programme of Action of the International Conference on Population and Development requires political support and advocacy, understood here as a full commitment to its principles, goals and objectives. Effective advocacy is essential in creating awareness of reproductive rights and reproductive health and can be facilitated by the use of effective information, education and communication strategies. The importance of information, education and communication in the area of reproductive rights and reproductive health derives from the recognition that they are important instruments that stimulate attitudinal and behavioural changes. In the area of human reproduction and health, various strategies have been used in attempts to develop positive attitudes and encourage responsible and healthy behaviour, help increase community participation in population activities and facilitate acceptance of population programmes in diverse cultural settings.

97. A primary aim of information, education and communication activities should be to motivate policy makers, programme managers, service providers and communities to translate into action the concept of reproductive rights and reproductive health, including family planning. This will require the strengthening of national capacities to undertake appropriate information, education and communication activities. It will also require that information, education and communication messages be effective and that service-delivery systems respond to the increased demand that those messages contribute to generating.

98. There is a large variety of information, education and communication programmes that combine strategies of mass, group and one-to-one communication approaches and that use different channels, from interpersonal and peer support to formal school curricula, from traditional and folk media to mass entertainment and news media, and production and dissemination of specific materials. The spectrum of activities includes a large array of operations that covers awareness-raising campaigns, art exhibits, painting and poster competitions; design, development and distribution of information, education and communication and training materials; printing and distribution of booklets, brochures and comic books with family planning, sexual health and HIV/AIDS prevention messages; radio and television programmes, particularly soap operas with family planning and HIV/AIDS themes; dramas and puppet shows; seminars and workshops; telephone hot lines; and preventive counselling, including the distribution of condoms. When planned in a coordinated and strategic manner, these activities can make a significant contribution to the impact of population programmes.

99. Three key issues have been identified in population information, education and communication programmes. First, social, cultural and political conditions can affect the recognition of reproductive rights and may limit access to reproductive health services and information; myths and ignorance may constitute major obstacles. Secondly, information, education and communication activities are not always properly linked to the delivery of reproductive health and family planning information and services. And thirdly, there is a need for adequate indicators for measuring progress in this field.

100. Population policies and legislation have a major role to play in the creation of a supportive environment for reproductive health and family planning. Information, education and communication activities are facilitated when they are supported by population policies and appropriate legislation. It is also recognized that information, education and communication activities are valuable instruments for facilitating the understanding and acceptance of the goals and objectives of population policies.

101. Reproductive health and family planning programmes are usually a major component of national population policies and strategies, and information, education and communication activities provide strong programme support. Strengthening their links will make them mutually supportive and thus enable national programmes to better satisfy unmet demands through the delivery of high-quality reproductive health and family planning services. Many of these programmes include also the prevention and control of sexually transmitted diseases and HIV/AIDS and information, education and communication activities that are valuable tools in reaching groups at risk, especially adolescents, and in raising awareness and promoting behavioural change.

102. Population education is another common strategy adopted by Governments as part of their population policies. Population education programmes usually cover topics that range from population dynamics to pregnancy and family planning, family life, sex education and, more recently, new ways of looking at gender issues, and HIV/AIDS and sexually transmitted diseases. There is increasing evidence that sex and HIV/AIDS education programmes may reduce unsafe practices among sexually active adolescents and reduce early pregnancies.

103. The Programme of Action of the International Conference on Population and Development calls for a coordinated strategic approach to information, education and communication that should be linked to, and complement, national population and development policies and strategies and a full range of services in reproductive health, including family planning and sexual health (United Nations, 1995a, chap. I, resolution 1, annex, para. 11.19). Achieving such an objective requires that special attention be given to the following priority areas:

(a) Data requirements, indicators and future research. The development of appropriate mechanisms for collecting data and of instruments for assessing and evaluating programme effects should receive high priority. Assistance to country programmes for developing or strengthening their information systems for the management of information, education and communication programmes should be a priority;

(b) Adolescents. Because of the critical stage of their personal development, young people, particularly adolescents, have a special need for information on sexual and reproductive health, as well as on such other related issues as substance abuse and violence. Most young people are exposed to the mass media, classroom education and the influence of their family members, peers and the community at large and it is through these three principal channels that they gain the information, education and skills required to advance through the difficult passage to adulthood. The provision of information about sexuality, pregnancy and sexually transmitted diseases, combined with information about

local services and counselling availability, is an effective way of assisting young people. Their participation in such activities can help ensure that the messages are appropriate and compelling to their peers. They can also be involved in facilitating the community dialogue and debate that should be linked to those efforts. Youth organizations can also play a major role in health promotion for youth both in and out of school and contribute to making young people's immediate environment more supportive. Youth groups can make linkages with the health sector and help make health services more "youth-friendly". Such organizations can also play a role in involving parents and helping them understand and provide support to their adolescent children;

(c) Gender equality and equity. The Programme of Action affirms that the full participation and partnership of both women and men is required in reproductive life. Education and information that promote such aims, along with responsible sexuality and respect for women, are also fundamental to improving the status and role of women in society. Increasing the education given to girls and women contributes to their empowerment and to improved family health. Expanding women's knowledge of reproductive health and expanding their choices enables them to meet their reproductive goals. Information, education and communication activities can contribute to eradicating harmful practices against women and girls, such as female genital mutilation; drawing attention to the health needs of the girl child; eliminating nutrition practices that discriminate against girls; involving men in reproductive health and family planning programmes; removing barriers to women's rights and enforcing legislation on early marriage, sexual exploitation and violence; and in ensuring that women have equal access to education, are guaranteed equal opportunity to work and receive equal pay for equal work;

(d) Participation of programme users. Participation of programme users in the design, implementation and evaluation of information, education and communication programme interventions increases the likelihood of the success of those programmes. Various population groups have their own perspectives, ideas and opinions in many areas, particularly about sexual and reproductive health issues. Communicating effectively with them requires their direct participation;

(e) Training of personnel. Health professionals should be trained in basic information, education and communication matters to cater to the special needs of the populations they serve, including the areas of interpersonal communication, sexuality and counselling, as well as team building, that will promote work with social welfare workers, teachers, parents and community leaders. Training of educators and student peers to work with other students in educational and counselling activities should focus on techniques dealing with problem-solving, listening, non-judgmental communication, conflict resolution, decision-making, counselling and basic education, as well as sexual and reproductive health needs.

## Notes

1/ Unsafe abortion is defined as a procedure for terminating an unwanted pregnancy either by persons lacking the necessary skills or in an environment lacking the minimal medical standards or both (based on WHO, The Prevention and Management of Unsafe Abortion, Report of a Technical Working Group (Geneva), WHO/MSM/92.5). This definition was used in the Programme of Action of the International Conference on Population and Development, (Report of the International Conference on Population and Development, Cairo, 5-13 September 1994 (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex).

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